MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes (x) No
Requestor's Name and Address RHD Memorial Medical Center P O BOX 809053 Dallas, Texas 75380	MDR Tracking No.: M4-04-1861-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address TPCIGA For Legion Insurance Company C/o Wilson-Grosenheider & Jacobs, L.L.P. P O BOX 1584 Austin, Texas 78776	Date of Injury: Employer's Name: Ceiling Doctor Insurance Carrier's No.: 900000653

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10-11-02	10-12-02	Admission	$30,885.73	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Carrier paid inpatient per diem, less a contract discount and requested implant invoices. The discount is incorrect. Stop loss calculation was not applied.

PART IV: RESPONDENT'S POSITION SUMMARY

Provider is not entitled to additional reimbursement. First, provider cannot refuse to produce its cost invoices for the implants simply because the services exceed $40,000. In order to qualify for stop-loss reimbursement, two criteria must be met (1) audited charges must exceed $40,000.00 and (2) the services provided should be unusually extensive and costly.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by the provider, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was one (1) day (consisting of 1 day for surgical). Accordingly, the standard per diem amount due for the admission is equal to $1,118.00 (1 X $1,118.00), however, the requestor only billed $1,001.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT scans/pharmaceuticals) as follows:

Requestor did not provide invoice for implantables therefore reimbursement cannot be determined.

The carrier has reimbursed the provider in the amount of $1,006.20.

Considering the reimbursement amount calculated in accordance with the provisions of Rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

Authorized Signature	Typed Name	03-03-05 Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____